FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035188

Facility Name: Lexington Health Care Center-Bloomingdale

Address: 165 S. Bloomingdale Road (Number) Bloomingdale (City) 60108 (Zip Code)

County: Dupage

Telephone Number: (630) 980-8700 **Fax #** (630) 980-6170

IDPA ID Number: 363635151001

Date of Initial License for Current Owners: 05/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	172	Skilled (SNF)	172	62,952	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,952	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,148	3,455	8,020	35,623	8
9	SNF/PED					9
10	ICF	16,336	2,039	344	18,719	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,484	5,494	8,364	54,342	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.32%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 172 and days of care provided 6,964

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	267,568	31,453	10,530	309,551		309,551		309,551			1
2	Food Purchase		228,028		228,028		228,028	(9,710)	218,318			2
3	Housekeeping	220,448	28,434		248,882		248,882	249	249,131			3
4	Laundry	47,202	18,805		66,007		66,007	(1,940)	64,067			4
5	Heat and Other Utilities			199,568	199,568		199,568	2,843	202,411			5
6	Maintenance	21,341		104,532	125,873		125,873	36,529	162,402			6
7	Other (specify):* **Allocated Benefits**							4,111	4,111			7
8	**TOTAL General Services**	556,559	306,720	314,630	1,177,909		1,177,909	32,082	1,209,991			8
	B. Health Care and Programs											
9	Medical Director			5,675	5,675		5,675		5,675			9
10	Nursing and Medical Records	2,504,733	184,286	200,375	2,889,394		2,889,394	48,021	2,937,415			10
10a	Therapy			646,896	646,896		646,896		646,896			10a
11	Activities	176,692	13,368	3,561	193,621		193,621		193,621			11
12	Social Services	72,161		2,717	74,878		74,878		74,878			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Allocated Benefits**							5,807	5,807			15
16	**TOTAL Health Care and Programs**	2,753,586	197,654	859,224	3,810,464		3,810,464	53,828	3,864,292			16
	C. General Administration											
17	Administrative	96,168		781,562	877,730		877,730	(700,739)	176,991			17
18	Directors Fees											18
19	Professional Services			67,758	67,758		67,758	7,494	75,252			19
20	Dues, Fees, Subscriptions & Promotions			15,778	15,778		15,778	745	16,523			20
21	Clerical & General Office Expenses	187,375	36,102	24,949	248,426		248,426	223,650	472,076			21
22	Employee Benefits & Payroll Taxes			490,555	490,555		490,555	9,710	500,265			22
23	Inservice Training & Education			1,209	1,209		1,209		1,209			23
24	Travel and Seminar			3,309	3,309		3,309	3,102	6,411			24
25	Other Admin. Staff Transportation			11,425	11,425		11,425	7,979	19,404			25
26	Insurance-Prop.Liab.Malpractice			147,214	147,214		147,214	3,552	150,766			26
27	Other (specify):* **Allocated Benefits**							35,030	35,030			27
28	**TOTAL General Administration**	283,543	36,102	1,543,759	1,863,404		1,863,404	(409,477)	1,453,927			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,593,688	540,476	2,717,613	6,851,777		6,851,777	(323,567)	6,528,210			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale #0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			75,427	75,427		75,427	179,454	254,881			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,991	6,991		6,991	278,795	285,786			32
33	Real Estate Taxes							111,742	111,742			33
34	Rent-Facility & Grounds			1,070,475	1,070,475		1,070,475	(1,069,330)	1,145			34
35	Rent-Equipment & Vehicles			3,135	3,135		3,135	2,416	5,551			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,156,028	1,156,028		1,156,028	(496,923)	659,105			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		192,837		192,837		192,837		192,837			39
40	Barber and Beauty Shops			18,125	18,125		18,125		18,125			40
41	Coffee and Gift Shops			1,228	1,228		1,228		1,228			41
42	Provider Participation Fee			94,428	94,428		94,428		94,428			42
43	Other (specify):* Nonallowable Costs			218,747	218,747		218,747	(218,747)				43
44	**TOTAL Special Cost Centers**		192,837	332,528	525,365		525,365	(218,747)	306,618			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,593,688	733,313	4,206,169	8,533,170		8,533,170	(1,039,237)	7,493,933			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,014)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,940)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,938)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(904)	43		13
14	Non-Care Related Interest	(3,800)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13)	43		18
19	Entertainment				19
20	Contributions	(2,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(188,485)	43		24
25	Fund Raising, Advertising and Promotional	(11,815)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,767)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	105,277			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (118,899)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(920,338)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (920,338)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,039,237)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/04 - 12/31/04

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(6,672)	19
Offset miscellaneous income	(413)	21
Disallow unclaimed property expense	(4,061)	21
Unrealized gain resulting from interest rate swap	129,635	43
Disallow personal item replacement	(455)	43
Disallow radiology	(9,143)	43
Disallow laboratory	(2,811)	43
Disallow out of period legal fees	(803)	19
Total	105,277	

See Accountants' Compilation Report

STATE OF ILLINOIS

Lexington Health Care Center-Bloomingdale

ID# 0035188

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	249	0	0	0	0	0	0	0	0	249	3
4	Laundry	(1,940)	0	0	0	0	0	0	0	0	0	0	(1,940)	4
5	Heat and Other Utilities	0	0	2,843	0	0	0	0	0	0	0	0	2,843	5
6	Maintenance	0	0	36,529	0	0	0	0	0	0	0	0	36,529	6
7	Other (specify):*	0	0	4,111	0	0	0	0	0	0	0	0	4,111	7
8	**TOTAL General Services**	(1,940)	0	43,732	0	0	0	0	0	0	0	0	41,792	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	48,021	0	0	0	0	0	0	0	0	48,021	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	5,807	0	0	0	0	0	0	0	0	5,807	15
16	**TOTAL Health Care and Programs**	0	0	53,828	0	0	0	0	0	0	0	0	53,828	16
	C. General Administration													
17	Administrative	0	0	80,823	(781,562)	0	0	0	0	0	0	0	(700,739)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	248	14,721	0	0	0	0	0	0	0	0	14,969	19
20	Fees, Subscriptions & Promotions	0	0	745	0	0	0	0	0	0	0	0	745	20
21	Clerical & General Office Expenses	0	50	228,074	0	0	0	0	0	0	0	0	228,124	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,102	0	0	0	0	0	0	0	0	3,102	24
25	Other Admin. Staff Transportation	0	0	0	7,979	0	0	0	0	0	0	0	7,979	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,552	0	0	0	0	0	0	0	3,552	26
27	Other (specify):*	0	0	0	35,030	0	0	0	0	0	0	0	35,030	27
28	**TOTAL General Administration**	0	298	327,465	(735,001)	0	0	0	0	0	0	0	(407,238)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,940)	298	425,025	(735,001)	0	0	0	0	0	0	0	(311,618)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	155,339	0	24,115	0	0	0	0	0	0	0	179,454	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,738)	291,241	0	292	0	0	0	0	0	0	0	278,795	32
33	Real Estate Taxes	0	110,475	0	1,267	0	0	0	0	0	0	0	111,742	33
34	Rent-Facility & Grounds	0	(1,070,475)	0	1,145	0	0	0	0	0	0	0	(1,069,330)	34
35	Rent-Equipment & Vehicles	0	0	0	2,416	0	0	0	0	0	0	0	2,416	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(12,738)	(513,420)	0	29,235	0	0	0	0	0	0	0	(496,923)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(209,498)	(126,475)	0	0	0	0	0	0	0	0	0	(335,973)	43
44	TOTAL Special Cost Centers	(209,498)	(126,475)	0	0	0	0	0	0	0	0	0	(335,973)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(224,176)	(639,597)	425,025	(705,766)	0	0	0	0	0	0	0	(1,144,514)	45

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of Bloomingdale		
See attached Schedule B		See attached Schedule B		Limited Partnership	Bloomingdale	Real estate ptsp.
				Royal Mgmt. Corp	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,070,475	Sambell of Bloomingdale Limited Partnership	**	$	$ (1,070,475)	1
2	V	19	Professional fees		Sambell of Bloomingdale Limited Partnership	**	248	248	2
3	V	21	Bank charges		Sambell of Bloomingdale Limited Partnership	**	50	50	3
4	V	30	Depreciation		Sambell of Bloomingdale Limited Partnership	**	155,339	155,339	4
5	V	32	Interest expense		Sambell of Bloomingdale Limited Partnership	**	286,610	286,610	5
6	V	32	Amortization of mortgage costs		Sambell of Bloomingdale Limited Partnership	**	4,631	4,631	6
7	V	33	Property taxes		Sambell of Bloomingdale Limited Partnership	**	110,475	110,475	7
8	V	43	State replacement tax		Sambell of Bloomingdale Limited Partnership	**	3,160	3,160	8
9	V	43	Unrealized gain		Sambell of Bloomingdale Limited Partnership	**	(129,635)	(129,635)	9
10	V								10
11	V								11
12	V				** Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100%				12
13	V				of Sambell of Bloomingdale Limited Partnership				13
14	Total			$ 1,070,475			$ 430,878	$ * (639,597)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/04 - 12/31/04

Schedule B

VII. Related Parties
Owners

Name	Ownership %
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 249	$ 249	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	2,703	2,703	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	72	72	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	68	68	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	33,994	33,994	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	2,535	2,535	20
21	V	7	Management allocation - employee benefits		Royal Management Corp.	**	4,111	4,111	21
22	V	10	Management allocation - salaries		Royal Management Corp.	**	48,021	48,021	22
23	V	15	Management allocation - employee benefits		Royal Management Corp.	**	5,807	5,807	23
24	V	17	Management allocation - salaries		Royal Management Corp.	**	80,823	80,823	24
25	V	19	Computer consultant & supplies		Royal Management Corp.	**	9,048	9,048	25
26	V	19	Professional fees		Royal Management Corp.	**	5,673	5,673	26
27	V	20	Dues & subscriptions		Royal Management Corp.	**	668	668	27
28	V	20	Licenses, permits & inspections		Royal Management Corp.	**	18	18	28
29	V	20	Advertising - help wanted		Royal Management Corp.	**	59	59	29
30	V	21	Management allocation - salaries		Royal Management Corp.	**	208,858	208,858	30
31	V	21	Bank charges		Royal Management Corp.	**	1,661	1,661	31
32	V	21	Office supplies & printing		Royal Management Corp.	**	7,059	7,059	32
33	V	21	Postage		Royal Management Corp.	**	2,891	2,891	33
34	V	21	Telephone		Royal Management Corp.	**	7,605	7,605	34
35	V	24	Travel & seminar		Royal Management Corp.	**	3,102	3,102	35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Bloomingdale, Inc. Own 100% of Royal Management Corp.						38
39	Total			$			$ 425,025	$ * 425,025	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 7,979	$ 7,979	15
16	V	26	Insurance general		Royal Management Corp.	**	3,552	3,552	16
17	V	27	Management allocation - employee benefits		Royal Management Corp.	**	35,030	35,030	17
18	V	30	Depreciation - vehicles		Royal Management Corp.	**	2,588	2,588	18
19	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	5,611	5,611	19
20	V	30	Depreciation - equipment		Royal Management Corp.	**	15,916	15,916	20
21	V	32	Interest		Royal Management Corp.	**	292	292	21
22	V	33	Property taxes		Royal Management Corp.	**	1,267	1,267	22
23	V	34	Rent expense		Royal Management Corp.	**	1,145	1,145	23
24	V	35	Equipment rental		Royal Management Corp.	**	2,416	2,416	24
25	V	17	Management fees	781,562	Royal Management Corp.	**		(781,562)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Bloomingdale, Inc. Own 100% of Royal Management Corp.						38
39	Total			$ 781,562			$ 75,796	$ * (705,766)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdal # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	3	6%	Salary	$ 26,895	L17, C7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	4%	Salary	19,211	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2	4%	Salary	19,211	L17, C7	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	3%	Salary	4,679	L17, C7	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	4	8%	Salary	10,827	L17, C7	5
6											6
7											7
8				All individuals worked in excess of 40 hours per week							8
9											9
10											10
11											11
12											12
13								TOTAL	$ 80,823		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188 **Schedule C**
1/1/04 - 12/31/04

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Chicago Ridge, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Elmhurst, Inc.	16,754	23,455	16,754	4,081	9,442	70,486
Lexington Health Care Center of LaGrange, Inc.	12,174	17,044	12,174	2,965	6,861	51,218
Lexington Health Care Center of Lake Zurich, Inc.	23,790	33,306	23,790	5,795	13,408	100,089
Lexington Health Care Center of Lombard, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Orland Park, Inc.	30,154	42,219	30,154	7,346	16,995	126,868
Lexington Health Care Center of Schaumburg, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Streamwood, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Wheeling, Inc.	24,684	34,557	24,684	6,012	13,912	103,849
Total	207,632	290,685	207,632	50,575	117,018	873,542

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	743,346	10	$ 2,938	$	62,952	$ 249	1
2	5	Utilities - gas & electric	Bed Days	743,346	10	31,920		62,952	2,703	2
3	5	Utilities - water & sewer	Bed Days	743,346	10	846		62,952	72	3
4	5	Utilities - maintenance office	Bed Days	743,346	10	808		62,952	68	4
5	6	Management allocation - salaries	Bed Days	743,346	10	401,410	401,410	62,952	33,994	5
6	6	Repairs & maintenance	Bed Days	743,346	10	29,930		62,952	2,535	6
7	7	Management allocation - employe	Bed Days	743,346	10	48,540		62,952	4,111	7
8	10	Management allocation - salaries	Bed Days	743,346	10	567,037	567,037	62,952	48,021	8
9	15	Management allocation - employe	Bed Days	743,346	10	68,569		62,952	5,807	9
10	17	Management allocation - salaries	Bed Days	743,346	10	954,365	954,365	62,952	80,823	10
11	19	Computer consultant & supplies	Bed Days	743,346	10	106,838		62,952	9,048	11
12	19	Professional fees	Bed Days	743,346	10	66,993		62,952	5,673	12
13	20	Dues & subscriptions	Bed Days	743,346	10	7,893		62,952	668	13
14	20	Licenses, permits & inspections	Bed Days	743,346	10	212		62,952	18	14
15	20	Advertising - help wanted	Bed Days	743,346	10	698		62,952	59	15
16	21	Management allocation - salaries	Bed Days	743,346	10	2,466,223	2,466,223	62,952	208,858	16
17	21	Bank charges	Bed Days	743,346	10	19,618		62,952	1,661	17
18	21	Office supplies & printing	Bed Days	743,346	10	83,348		62,952	7,059	18
19	21	Postage	Bed Days	743,346	10	34,142		62,952	2,891	19
20	21	Telephone	Bed Days	743,346	10	89,797		62,952	7,605	20
21	24	Travel & seminar	Bed Days	743,346	10	36,624		62,952	3,102	21
22										22
23										23
24										24
25	TOTALS					$ 5,018,749	$ 4,389,035		$ 425,025	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	743,346	10	$ 94,217	$	62,952	$ 7,979	1
2	26	Insurance general	Bed Days	743,346	10	41,943		62,952	3,552	2
3	27	Management allocation - employe	Bed Days	743,346	10	413,634		62,952	35,030	3
4	30	Depreciation - vehicles	Bed Days	743,346	10	30,557		62,952	2,588	4
5	30	Depreciation - leasehold improv.	Bed Days	743,346	10	66,255		62,952	5,611	5
6	30	Depreciation - equipment	Bed Days	743,346	10	187,937		62,952	15,916	6
7	32	Interest	Bed Days	743,346	10	3,446		62,952	292	7
8	33	Property taxes	Bed Days	743,346	10	14,963		62,952	1,267	8
9	34	Rent expense	Bed Days	743,346	10	13,526		62,952	1,145	9
10	35	Equipment rental	Bed Days	743,346	10	28,527		62,952	2,416	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 895,005	$		$ 75,796	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C.	X		Mortgage	Varies	2/1/96	5,575,000	4,348,750	02/01/2026	Variable	286,610	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	744,845	129,339	7/5/05	0.0300	3,800	6
7	Lasalle Bank N. A.		X	Working Capital	Varies	04/06/02	750,000	300,000	5/31/05	Prime	3,191	7
8												8
9	TOTAL Facility Related						$ 7,069,845	$ 4,778,089			$ 293,601	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			4,631	10
11								Interest Income offset			(8,938)	11
12								Management company allocation			292	12
13								Nonallowable shareholder interest			(3,800)	13
14	TOTAL Non-Facility Related						$	$			$ (7,815)	14
15	TOTALS (line 9+line14)						$ 7,069,845	$ 4,778,089			$ 285,786	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 114,000	1
	Allocated from management company	1,267	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 106,875	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,858)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 117,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 111,742	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	114,820	8
	2000	116,303	9
	2001	119,600	10
	2002	125,102	11
	2003	106,875	12
2004 tax assessment:		1,839,300	
Equalization factor:		1	
Tax rate:		0.06392	
Est. 2004 tax payable '05		117,563	
Use:		117600	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Bloomingdal COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-401-003	Land and building	$ 106,875.00	$ 106,875.00
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019		$ 187,600.00	$ 1,267.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 294,475.00	$ 108,142.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	43,000	1987	$ 402,548	1
2	Management Company allocation			13,578	2
3	TOTALS	43,000		$ 416,126	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1989	1989	$ 2,980,863	$	35	$ 85,192	$ 85,192	$ 1,334,675	4
5	9		1992	1992	178,974		35	5,114	5,114	66,479	5
6	75		1994	1994	2,022,894		35	57,797	57,797	606,868	6
7											7
8											8
	Improvement Type**										
9	Capitalized repairs			1989	9,080		10			9,080	9
10	Building Improvements			1990	3,674		10			3,674	10
11	Building Improvements			1991	2,586		10			2,586	11
12	Building Improvements			1992	3,154		10			3,154	12
13	Building Improvements			1993	1,582		10			1,582	13
14	Building Improvements			1994	15,734	786	10	786		15,734	14
15	Land Improvements			1994	1,381	69	10	69		1,381	15
16	Land Improvements			1995	1,074		15	72	72	680	16
17	Building Improvements			1995	1,288		35	37	37	276	17
18	Building Improvements			1995	9,433	270	35	270		2,565	18
19	Building Improvements			1995	43,839	1,252	35	1,252		11,894	19
20	Concrete flooring, fire doors, tile, sprinkler heads,										20
21	and basement renovation			1996	8,706	298	10-35	298		2,536	21
22	Land Improvements - drain tile system			1996	7,858		15	524	524	4,453	22
23	Resident room heaters			1997	3,563	102	35	102		815	23
24	Automatic doors			1997	12,950	370	35	370		2,621	24
25	Basement renovation			1997	58,806	5,936	10	5,936		42,540	25
26	Land Improvement - outdoor flagpoles			1997	1,574	105	15	105		787	26
27	1st Floor Remodel (Nurses Station/Lounge)			1998	76,487	7,649	10	7,649		49,717	27
28	Wiring for MDS			1998	4,506	451	10	451		2,930	28
29	Flag Pole			1998	787	79	10	79		512	29
30	Resurface/Stripe Parking Lot			1998	9,777	978	10	978		6,355	30
31	Kitchen tile/paint			1999	718	72	10	72		395	31
32	1st Floor Remodel			1999	3,296	330	10	330		1,978	32
33	Roof repairs			2000	5,748	383	15	383		1,724	33
34	Sump pump			2000	2,534	253	10	253		1,140	34
35	Sump pump basin repair			2000	6,307	631	10	631		2,839	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Automatic door closers	2000	$ 1,300	$ 87	15	$ 87	$	$ 390	37
38	Infrared curtains for elevator doors	2001	3,000	300	10	300		1,050	38
39	Ejector pump	2002	3,050	610	5	610		1,779	39
40	Lift station pump	2002	3,359	672	5	672		1,568	40
41	New asphalt parking lot	2003	16,450	1,645	10	1,645		1,919	41
42	Roof repairs	2003	2,900	290	10	290		314	42
43	Freezer/cooler repairs	2003	4,005	200	20	200		284	43
44	Kitchen remodel	2003	7,188	359	20	359		509	44
45	Painting/wallpaper/carpeting	2003	59,512	2,976	20	2,976		5,952	45
46	Floor tile	2003	16,305	815	20	815		1,630	46
47	Rehab-painting & decorating	2003	75,774	3,789	20	3,789		4,105	47
48	Rehab-floor tile	2003	8,117	406	20	406		440	48
49	Dining room remodel	2003	42,698	2,135	20	2,135		2,313	49
50	Foundation repair	2003	4,800	240	20	240		340	50
51	Parking lot	2004	24,550	1,023	10	1,023		1,023	51
52	Kitchen walk-in cooler floor	2004	7,161	239	10	239		239	52
53	Old Towne rehab	2004	13,967	175	20	175		175	53
54	Alzheimers remodel	2004	208,934	871	20	871		871	54
55									55
56									56
57									57
58									58
59									59
60									60
61	Land improvements - management company	2002	21,400		15	1,415	1,415	4,161	61
62	Building - management company	2002	166,493		40	4,069	4,069	12,140	62
63	HVAC, electrical, security system - management company	2003	1,650		30	114	114	157	63
64	Key card system - management company	2004	259		20	13	13	13	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,172,045	$ 36,846		$ 191,193	$ 154,347	$ 2,223,342	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,172,045	$ 36,846		$ 191,193	$ 154,347	$ 2,223,342	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,172,045	$ 36,846		$ 191,193	$ 154,347	$ 2,223,342	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 463,079	$ 35,145	$ 41,748	$ 6,603	5-10 years	$ 280,534	71
72	Current Year Purchases	72,863	3,436	3,436		5-10 years	3,436	72
73	Fully Depreciated Assets	295,736					295,736	73
74	Allocated from Mgmt. Co.	159,701		15,916	15,916		66,700	74
75	TOTALS	$ 991,379	$ 38,581	$ 61,100	$ 22,519		$ 646,406	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Mgmt. Co.			33,421		2,588	2,588		22,965	79
80	TOTALS			$ 33,421	$	$ 2,588	$ 2,588		$ 22,965	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,612,971	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 75,427	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 254,881	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 179,454	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,892,713	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Therapy room addition	$ 7,352	92
93			93
94			94
95		$ 7,352	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from management company				1,145			6
7	TOTAL				$ 1,145 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 5,551 Description: Postage meter: $179; Copier: $2,429; Fax machine: $527; Allocated from management company: $2,416
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	4,275	$ 224,315	$	4,275	$ 224,315	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		466	26,007		466	26,007	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		5,615	392,325		5,615	392,325	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				192,837		192,837	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Wound Therapy	L10A, C3				4,249			4,249	13
14	TOTAL			$	10,356	$ 646,896	$ 192,837	10,356	$ 839,733	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 266,843	$ 461,691	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 442,000)	1,421,784	1,421,784	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,939	8,939	6
7	Other Prepaid Expenses	25,065	25,065	7
8	Accounts Receivable (owners or related parties)	(8,932)	(10,001)	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,713,699	$ 1,907,478	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	54,306	54,306	12
13	Land		416,126	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	780,212	989,314	15
16	Equipment, at Historical Cost	468,106	1,024,800	16
17	Accumulated Depreciation (book methods)	(401,889)	(2,892,713)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Construction in progr	7,352	7,352	22
23	Other(specify): Unamortized Loan Costs		77,403	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 908,087	$ 4,859,319	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,621,786	$ 6,766,797	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 305,302	$ 305,302	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	429,339	429,339	29
30	Accrued Salaries Payable	163,532	163,532	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,999	4,999	31
32	Accrued Real Estate Taxes(Sch.IX-B)		117,600	32
33	Accrued Interest Payable		33,700	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	278,137	181,112	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,181,309	$ 1,235,584	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,348,750	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Interest Rate Swap		243,847	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,592,597	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,181,309	$ 5,828,181	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,440,477	$ 938,616	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,621,786	$ 6,766,797	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/04 - 12/31/04

Schedule E

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued PTP	49,164	49,164
Accrued Rent	97,025	
Accrued 401 (k) contribution	18,714	18,714
Due from related party	28,486	28,486
Other accrued expenses	84,748	84,748
Total line 36	278,137	181,112

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous income	413
Vending machine income	769
Interfacility help income	1,533
Investment income in Lexington Financial Services, L.L.C	1,037
Total line 28	3,752

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,315,239	1
2	Restatements (describe):		2
3	**Post closing adjustments**	(212,488)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,102,751	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	337,726	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 337,726	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,440,477	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,952,254	1
2	Discounts and Allowances for all Levels	(749,655)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,202,599	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,100,073	6
7	Oxygen	1,617	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,101,690	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,104	12
13	Barber and Beauty Care	21,895	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	33	15
16	Rental of Facility Space		16
17	Sale of Drugs	402,549	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,286	19
20	Radiology and X-Ray	12,339	20
21	Other Medical Services	91,771	21
22	Laundry	1,940	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 553,917	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,938	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,938	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	3,752	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,752	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,870,896	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,177,909	31
32	Health Care	3,810,464	32
33	General Administration	1,863,404	33
	B. Capital Expense		
34	Ownership	1,156,028	34
	C. Ancillary Expense		
35	Special Cost Centers	430,937	35
36	Provider Participation Fee	94,428	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,533,170	40
41	**Income before Income Taxes (line 30 minus line 40)****	337,726	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 337,726	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity files a cash basis return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,870	2,061	$ 100,608	$ 48.82	1
2	Assistant Director of Nursing	1,972	2,173	67,119	30.89	2
3	Registered Nurses	37,021	40,088	1,210,317	30.19	3
4	Licensed Practical Nurses	2,104	2,340	54,688	23.37	4
5	Nurse Aides & Orderlies	79,730	83,985	977,401	11.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,327	6,885	94,600	13.74	8
9	Activity Director	1,996	2,173	30,323	13.95	9
10	Activity Assistants	13,970	14,983	146,369	9.77	10
11	Social Service Workers	3,838	4,005	72,161	18.02	11
12	Dietician	2,062	2,078	27,739	13.35	12
13	Food Service Supervisor	1,878	2,169	33,691	15.53	13
14	Head Cook	1,958	2,038	22,882	11.23	14
15	Cook Helpers/Assistants	13,373	14,151	108,832	7.69	15
16	Dishwashers	11,726	12,124	74,424	6.14	16
17	Maintenance Workers	1,900	2,076	21,341	10.28	17
18	Housekeepers	29,957	31,955	220,448	6.90	18
19	Laundry	6,789	7,187	47,202	6.57	19
20	Administrator	2,126	2,251	96,168	42.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,429	12,161	187,375	15.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	232,026	246,883	$ 3,593,688 *	$ 14.56	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 10,530	L1, C3	35
36	Medical Director	38	5,675	L9, C3	36
37	Medical Records Consultant	19	1,042	L10, C3	37
38	Nurse Consultant	5	448	L10, C3	38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	74	3,561	L11, C3	44
45	Social Service Consultant	Monthly	2,167	L12, C3	45
46	Other(specify)				46
47	Rehabcare Consultant	Monthly	234	L10, C3	47
48	Religious Consultant	Monthly	550	L12, C3	48
49	TOTAL (lines 35 - 48)	328	$ 25,407		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,787	$ 95,730	L10, C3	50
51	Licensed Practical Nurses	3,086	55,551	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	7,873	$ 151,281		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patrick Scales	Administrator	0%	$ 96,168
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,168

B. Administrative - Other

Description	Amount
	$
Management fees (eliminated in column 7)	781,562
TOTAL (agree to Schedule V, line 17, col. 3)	$ 781,562
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Amalgamated Bank	Bond Consulting	$ 441
Altschuler, Melvoin & Glasser LLP	Accounting	21,202
American Express Tax & Bus. Svcs.	Accounting	4,347
Katten, Muchin, Zavis, Rosenman	Legal	1,025
James Samatas	Legal	274
Personnel Planners	U/C Consulting	1,095
Carol Jeschke	Staffing Consultant	2,562
Sachnoff & Weaver	Legal	18,489
Avail Corporation	Accounting	914
Grabowski Law Center, LLC	Collections	5,539
See attached Schedule F		11,870
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 67,758

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,413
Unemployment Compensation Insurance	41,210
FICA Taxes	260,691
Employee Health Insurance	93,244
Employee Meals	9,710
Illinois Municipal Retirement Fund (IMRF)*	
401(k) contribution	13,631
Other employee benefits	15,560
Life insurance	3,806
TOTAL (agree to Schedule V, line 22, col.8)	$ 500,265

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,132
Health Care Worker Background Check	
(Indicate # of checks performed)	
Miscellaneous Permits & Fees	1,171
Miscellaneous Dues & Subscriptions	1,475
Allocated from management company	745
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,523

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,309
Allocated from management company	3,102
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,411

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/04 - 12/31/04

Schedule F

XIX. Support Schedules
C. Professional Services

Vendor/Payee		
eHealth Solutions	Computer Consulting	3,600
Information Controls Inc.	Computer Consulting	867
Answers On Demand	Computer Consulting	2,652
Lanac	Computer Consulting	792
Adminastar	Computer Consulting	396
Gigatrend	Computer Consulting	195
National Datacare	Computer Consulting	1,551
XO Communications	Computer Consulting	169
Moody Investor Services	Financial Consulting	515
Various Consultants	Various Consulting	1,133
		11,870
Total, Agrees to Schedule V, Line 19, Column 3		67,758

Allocated from management co.

American Express Tax & Business Services	Accounting	255
Altschuler, Melvoin and Glasser LLP	Accounting	410
Account Temps	Accounting	701
Avail Corporation	Accounting	20
Doris Fischer	Medicaid Billing Consultant	1,803
Gene Whitehorn	Medicaid Billing Consultant	623
Susan Parker, LCSW	DNR Consulting	9
Personnel Planners	U/C Consulting	10
Gilson, Labus and Silverman	Accounting	212
James Samatas	Legal	30
Sachnoff and Weaver	Legal	840
ING / Pension Administrators	401 (k) Administration	736
Eric Haider	Consulting	22
Various	Computer Consulting	9,048

Allocated from building partnership

James Samatas	Annual report	250

Nonallowable legal fees

Grabowski Law Center, LLC	Collections	(5,539)
Various	Collections	(1,133)
Katten, Muchin, Zavis & Rosenman	Out of period legal fees	(790)
Sachnoff & Weaver	Out of period legal fees	(13)
Total, Agrees to Schedule V, Line 19, Column 8		75,252

See accountants' compilation report.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2							N/A						
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **44,188** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **94,428**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,710** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	267,568	31,453	10,530	309,551	0	309,551	0	309,551
2. Food Purchase	0	228,028	0	228,028	0	228,028	-9,710	218,318
3. Housekeeping	220,448	28,434	0	248,882	0	248,882	249	249,131
4. Laundry	47,202	18,805	0	66,007	0	66,007	-1,940	64,067
5. Heat and Other Utilities	0	0	199,568	199,568	0	199,568	2,843	202,411
6. Maintenance	21,341	0	104,532	125,873	0	125,873	36,529	162,402
7. Other (specify)*	0	0	0	0	0	0	4,111	4,111
8. Total General Services	556,559	306,720	314,630	1,177,909	0	1,177,909	32,082	1,209,991
9. Medical Director	0	0	5,675	5,675	0	5,675	0	5,675
10. Nursing & Medical Records	2,504,733	184,286	200,375	2,889,394	0	2,889,394	48,021	2,937,415
10a. Therapy	0	0	646,896	646,896	0	646,896	0	646,896
11. Activities	176,692	13,368	3,561	193,621	0	193,621	0	193,621
12. Social Services	72,161	0	2,717	74,878	0	74,878	0	74,878
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	5,807	5,807
16. Total Health Care & Programs	2,753,586	197,654	859,224	3,810,464	0	3,810,464	53,828	3,864,292
17. Administrative	96,168	0	781,562	877,730	0	877,730	-700,739	176,991
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	67,758	67,758	0	67,758	7,494	75,252
20. Fees, Subscriptions & Promotion	0	0	15,778	15,778	0	15,778	745	16,523
21. Clerical & General Office	187,375	36,102	24,949	248,426	0	248,426	223,650	472,076
22. Employee Benefits & Payroll	0	0	490,555	490,555	0	490,555	9,710	500,265
23. Inservice Training & Education	0	0	1,209	1,209	0	1,209	0	1,209
24. Travel and Seminar	0	0	3,309	3,309	0	3,309	3,102	6,411
25. Other Admin. Staff Trans	0	0	11,425	11,425	0	11,425	7,979	19,404
26. Insurance-Prop.Liab.Malpractice	0	0	147,214	147,214	0	147,214	3,552	150,766
27. Other (specify)*	0	0	0	0	0	0	35,030	35,030
28. Total General Adminis	283,543	36,102	1,543,759	1,863,404	0	1,863,404	-409,477	1,453,927
29. Total General Administrative	3,593,688	540,476	2,717,613	6,851,777	0	6,851,777	-323,567	6,528,210
30. Depreciation	0	0	75,427	75,427	0	75,427	179,454	254,881
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	6,991	6,991	0	6,991	278,795	285,786
33. Real Estate	0	0	0	0	0	0	111,742	111,742
34. Rent - Facility & Grounds	0	0	1,070,475	1,070,475	0	1,070,475	-1,069,330	1,145
35. Rent - Equipment & Vehicles	0	0	3,135	3,135	0	3,135	2,416	5,551
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,156,028	1,156,028	0	1,156,028	-496,923	659,105
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	192,837	0	192,837	0	192,837	0	192,837
40. Barber and Beauty Shop	0	0	18,125	18,125	0	18,125	0	18,125
41. Coffee and Gift Shops	0	0	1,228	1,228	0	1,228	0	1,228
42. Provider Participation	0	0	94,428	94,428	0	94,428	0	94,428
43. Other (specify):*	0	0	218,747	218,747	0	218,747	-218,747	0
44. Total Special Cost Ce	0	192,837	332,528	525,365	0	525,365	-218,747	306,618
45. Grand Total	3,593,688	733,313	4,206,169	8,533,170	0	8,533,170	-1,039,237	7,493,933

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	266,843	461,691
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,421,784	1,421,784
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	8,939	8,939
7. Other Prepaid Expenses	25,065	25,065
8. Accounts Receivable-Owner/Related Party	-8,932	-10,001
9. Other (specify):	0	0
10. Total current assets	1,713,699	1,907,478
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	54,306	54,306
13. Land	0	416,126
14. Buildings, at Historical Cost	0	5,182,731
15. Leasehold Improvements, Historical Cost	780,212	989,314
16. Equipment, at Historical Cost	468,106	1,024,800
17. Accumulated Depreciation (book methods)	-401,889	-2,892,713
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	7,352	7,352
23. other (specify):	0	77,403
24. Total Long-Term Assets	908,087	4,859,319
25. Total Assets	2,621,786	6,766,797
CURRENT LIABILITIES		
26. Accounts Payable	305,302	305,302
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	429,339	429,339
30. Accrued Salaries Payable	163,532	163,532
31. Accrued Taxes Payable	4,999	4,999
32. Accrued Real Estate Taxes	0	117,600
33. Accrued Interest Payable	0	33,700
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	278,137	181,112
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,181,309	1,235,584
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	4,348,750
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	243,847
45.Total Long-Term Liabilities	0	4,592,597
46.Total Liabilities	1,181,309	5,828,181
47.Total Equity	1,440,477	938,616
48.Total Liabilities and Equity	2,621,786	6,766,797

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,952,254
2. Discounts and Allowances for all Levels	-749,655
Subtotal - Inpatient Care	7,202,599
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,100,073
7. Oxygen	1,617
Subtotal - Anciliary Revenue	1,101,690
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	1,104
13. Barber and Beauty Care	21,895
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	33
16. Rental of Facility Space	0
17. Sale of Drugs	402,549
18. Sale of Supplies to Non-Patients	0
19. Laboratory	22,286
20. Radiologyand X-Ray	12,339
21. Other Medical Services	91,771
22. Laundry	1,940
Subtotal - Other Operating Revenue	553,917
24. Contributions	0
25. Interest and Other Investments Income	8,938
Subtotal - Non-Operating Revenue	8,938
27. Other Revenue (specify):	0
28. Other Revenue (specify):	3752
Subtotal - Other Revenue	3,752
30. Total Revenue	8,870,896
31. General Services	1,177,909
32. Health Care	3,810,464
33. General Administration	1,863,404
34. Ownership	1,156,028
35. Special Cost Centers	430,937
35. Provider Participation Fee	94,428
37. Other	0
40. Total Expenses	8,533,170
41. Income Before Income Taxes	337,726
42. Income Taxes	0
43. Net Income or Loss for the Year	337,726

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